

# New Member Enrollment Form

Form Last Revised: October, 2001

**Retirement  
Board:** Please  
place your address  
and phone  
number here. ▶

ESSEX REGIONAL RETIREMENT BOARD  
491 MAPLE ST, BLDG. 200, SUITE 202  
DANVERS, MA 01923-4025

## Employee Name

Last  First  M.I.  -  Social Security #  Sex

## Address

Street and Number  City/Town  State  Zip  ( ) Phone #

Birth Name or Former Name (if different)  Date of Birth\* ☐ M ☐ S ☐ W ☐ D Marital Status

Spouse's Date of Birth  # of Children

Agency or Department\*\*  Title/Position  Starting Date of Present Service

\* The retirement board may request a copy of birth records, military discharge papers and other pertinent data.

\*\* For those retiring from regional or county retirement system, please identify the community.

Are you retired from any other Massachusetts public retirement system? ☐ Yes ☐ No

Were you ever a member of any other Massachusetts public retirement system? ☐ Yes ☐ No

## List prior or current public retirement system membership:

### SYSTEM

<input type="text"/>
<input type="text"/>
<input type="text"/>

### DATES OF MEMBERSHIP

<input type="text"/>	to	<input type="text"/>
<input type="text"/>	to	<input type="text"/>
<input type="text"/>	to	<input type="text"/>

### ARE YOUR FUNDS STILL ON DEPOSIT?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you wish to purchase past creditable service, you must make that request in writing of the relevant retirement system and produce acceptable proof of such service.

Did you ever work for or do you currently work for the Commonwealth or one of its political subdivisions for which you were not/are not a contributing member of a retirement system? ☐ Yes ☒ No



Member's Last Name First M.I. Social Security #

**List prior or current employment with the Commonwealth or one of its political subdivisions****(Non-membership) :**

EMPLOYER

DATES OF EMPLOYMENT

<input type="text"/>	<input type="text"/> to <input type="text"/>
<input type="text"/>	<input type="text"/> to <input type="text"/>
<input type="text"/>	<input type="text"/> to <input type="text"/>

Are you a Veteran?\* ☐ Yes ☐ No Dates of Active Duty Service  to

**\* The retirement board may request a copy of birth records, military discharge papers and other pertinent data.**

I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth. In the event that I die before retiring, my beneficiary or beneficiaries may receive survivor benefits or a refund of my accumulated total deductions as allowed by law.

I sign this form under the pains and penalties of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**To Be Completed by Payroll/Personnel Department and Verified by Retirement Board:**

Check base rate to be deducted for retirement:

☐ 5% ☐ 7% ☐ 8% ☐ 9% ☐ Additional 2%

If 5% or 7% or 8%, state reason:

Current Rate of Regular Compensation per Pay Period:

Employment Status (Check all that apply):

☐ Permanent ☐ Temporary ☐ Full-time ☐ Part-time: ☐ 50% ☐ 75% ☐ Other \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name

**To Be Completed by the Retirement Board:**

Membership Date \$  Annual Regular Compensation  % to be deducted

☐ Group Classification

The member must also complete the Beneficiary Selection Form

# Beneficiary Selection Form (If Member Dies Before Retirement)

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## Choice of Beneficiary to Receive a Return of Accumulated Total Deductions at Member's Death

I, (Print Name) , a member of the   
Retirement System hereby request the Board of Retirement to pay any sum referred to in G.L. c. 32, § 11(2)\*  
due at my death to the following beneficiary or beneficiaries in the proportions designated.

My selection may be superseded by a selection under G.L. c. 32, § 12(2)(d) if I die leaving an eligible spouse  
who elects to receive a monthly benefit.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon  
my retirement, this form becomes void.

\*The types of payments covered under G.L. c. 32, § 11(2) include:

- The payment of the accumulated deductions credited to a member's account in the annuity savings fund at  
the date of death when the member's death occurs prior to his/her retirement.
- The amount of any uncashed checks payable to a member at his or her death.
- Any person or entity may be a beneficiary under G.L. c. 32, § 11(2). Give complete name and address of  
each beneficiary below:

		Proportion To Be Paid
Name	<input type="text"/>	SSN <input type="text"/> - <input type="text"/> - <input type="text"/>
Address	<input type="text"/>	
Name	<input type="text"/>	SSN <input type="text"/> - <input type="text"/> - <input type="text"/>
Address	<input type="text"/>	
Name	<input type="text"/>	SSN <input type="text"/> - <input type="text"/> - <input type="text"/>
Address	<input type="text"/>	
Name	<input type="text"/>	SSN <input type="text"/> - <input type="text"/> - <input type="text"/>
Address	<input type="text"/>	

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Member's Address



Member's Last Name First M.I. Social Security #

**To Be Completed by Witness of Choice of Beneficiary of Accumulated Total Deductions.**

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Name of Witness (Print) \_\_\_\_\_

**Choice of Option (D) Beneficiary**

I, (Print Name) , a member of the  Retirement System, hereby nominate the beneficiary \* listed below, under the provisions of G.L. c. 32, § 12(2)(d) to receive from the retirement system a benefit equal to the Option (C) retirement allowance which would otherwise have been payable to me in the event that I die before being retired.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I understand that this choice of Option D Beneficiary can be superceded if, at my death, I leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death, or if living apart, for justifiable cause as determined by the Retirement Board.

**Beneficiary**

Name of Eligible Beneficiary Beneficiary's Relationship to Member  
   
Beneficiary's Date of Birth (Attach birth record) Beneficiary's Social Security #

**Member**

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Member's Street Address Member's Social Security #

City/Town State Zip

**To Be Completed by Witness of Choice of Option D Beneficiary**

Witness' Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness' Name (Print)

\* An eligible beneficiary is defined under G.L. c. 32, § 12(2)(d) as the spouse, former spouse who has not remarried, child, father, mother, sister or brother of the member.